B. Five Year Needs Assessment

I. Process of Conducting Needs Assessment

The Ministry of Health took the initiatives this year to conduct various sessions involving the staff from various departments and programs within the Ministry to be involved in evaluating the programs and services in Public Health, including the Reproductive Health/Maternal and Child Health. The 10 Essentials Public Health Functions (EPHF) were used as guidelines to evaluate services that Ministry is providing to the population.

The first three-day session of the needs assessment involved close to 60 participants from the Ministry of Health representing MOH senior staff, physicians, nurses, supervisors and director from five of the six bureaus in the Ministry. The process included presentations of the 10 Essential Public Health Functions and questions that allow for the participants to assess the programs and services in the Ministry. For each essential functions, a selected staff would do the presentation on the current delivery of health services. Questions will be presented on how to improve services and discussions will then take place.

The 10 EPHF include the following:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services; and
10. Research for new insights and innovative solutions to health problems.

These EPHF clearly spell out the need to evaluate and assess each of the program areas within the Ministry to ensure the health care services that the Ministry provides is accessible and community oriented. The Reproductive Health Services/MCH is no different from the other programs.

Second session of needs assessment took place with various government agencies and private sector organizations and women's groups. There were 25 participants during this second session which lasted three working days. The same questions related to the 10 EPHF were presented and discussed during the sessions. A lot of recommendations were presented to the Ministry on how to improve delivery of health care services.

During the year, the process of reviewing data and assess the programs and services within the Ministry continued. The Bureau of Health Planning and Statistics continued to provide data on all RH/MCH programs and services for the senior staff to review. The Ministry used the documents listed during process of needs assessment in order to evaluate the programs services in RH/MCH/CSHCN.

1. MOH Annual Report for Fiscal Year 2004
2. The 2004 Statistical Reports from the National Economic Planning and Social Statistics Office (EPPSO)
3. MOH 15-Year Strategic Plan
4. MOH Annual Reports 2001-2003
5. MOH FY 2005 Quarterly Reports
6. PHC Assessment 2005
7. Quarterly reports from each program area
8. Recommendations from the two seminars/meetings on the 10 EPHF
9. Other related documents on reproductive health and MCH/CSHCN services.

II. Needs Assessment Partnership Building and Collaboration

The Ministry of Health is the state health department that, under the Marshall Islands Constitution, is the only agency that provides for high quality, accessible and affordable health care services to the populations of the Marshall Islands. The Mission Statement clearly states the goal of the Ministry of Health:

> ***"To provide high quality, effective, affordable, and efficient health services to all people of the Marshall Islands, through a primary health care program to improve the health status and build the capacity of each community, family and the individual to care for their own health. To the maximum extend possible, the Ministry of Health pursues these goals using the national facilities, staff and resources of the Republic of the Marshall Islands".***

The Ministry of Health is comprised of six different bureaus headed by an Assistant Secretary of Health with a total of 455 staff in the urban centers and outer islands. Three bureaus namely the Bureau of Majuro Hospital Services, the Bureau of Kwajalein Atoll Health Care (KAHC) Services and the Bureau of Primary Health Care (PHC) are the three main bureaus that provides direct health care services. Majuro Hospital concentrates on patient care and ambulatory services while the Bureau of PHC concentrates on preventive services. KAHC Bureau has both the hospital and primary health care services.

The Bureau of PHC has four divisions.

1. Division of Public Health is the largest with six program areas:

- Reproductive Health Services/MCH/CSHCN – conduct prenatal clinics, postpartum clinics, family planning clinics, STD screening and treatment, high-risk clinic and CSHCN.

- Immunization Program – immunize the children, students and adults including pregnant mothers who come for prenatal care.
- TB/Leprosy Program – conduct screening and treatment for TB and leprosy during clinics, visits to the schools and communities and also during prenatal clinics.
- Chronic Disease Control Program – provide treatment and screening for diabetes, hypertension in the clinics and outreach to the schools and communities, including diabetes gestational.
- STD/HIV Program – screening and treatment is provided in all the clinics, including prenatal and during outreach to the schools and communities in the urban center as well as those in the outer islands.

2. Dental Services is also one of the divisions in PHC. Dental services provides clinical services for all three MCH populations; dental preventive services through the school sealant program; community outreach to the outer islands and CSHCN.

3. Division of Health Promotions and Human Services has four areas of services:

- Health education and promotions where staff would conduct educational sessions during prenatal clinics; dissemination of educational materials during clinics and outreach; provide health messages in the weekly newspaper and on the weekly Health Education Radio program; and collaborate with community groups on community awareness and outreach activities.
- Nutrition and Diabetes Prevention Program where patients will be referred to for counseling on nutrition, exercise and healthy diets; families of children diagnosed with malnutrition will be referred to for counseling and follow-up at home after discharged; families of CSHCN received also counseling on nutrition and healthy diet from the staff in this division.
- Social Work Program has staff who conducts home visits with children, spouses and youths who are referred from the Emergency Room and the Police Station for sexual assaults, attempt suicides, and domestic violence. The program also are on 24-hours standby with the police to provide counseling to family members of suicide cases.
- Mental Health Program which work closely with clients who have special health care needs in the area of mental health. Staff members provide counseling services, medication to clients who need to have prescribed drugs, conduct home visit daily to assess the needs of the clients and their families and conduct weekly support group meeting to ensure families receive the support for confidence in taking care of their family members who have special needs physically and those enrolled in the Mental Health Program.

4. Division of Outer Islands Health Care Services which concentrates on providing health care services to those populations living in the outer islands. Because of the limited medical supplies, equipment and other needs, the health teams from the urban centers visit the outer islands on a regular basis to immunize the children, screening for

CSHCN, provide dental services, conduct special clinics for diabetics, STD/HIV and follow-up with TB/.Leprosy patients and families.

Collaboration between the bureaus within the Ministry of Health is an integrated part of the health care system. The three bureaus mentioned with various program areas collaborate in providing the services, traveling to outer islands, patient care in the hospital and upon discharge and outreach clinics and activities both in the urban center and in the outer islands.

No program is independent or on its own within the Ministry of Health. Although the Bureau of Health Planning and statistics does not provide direct health care services, the bureau is responsible for collection of all data for all six bureaus within the Ministry. Collaboration between the bureaus is therefore necessary keeping in mind the Ministry's theme, "Health Is a Shared Responsibility".

III. Assessment of Needs of the Maternal and Child Health Population Groups

The data from the Bureau of Health Statistics and Planning during the past five years describe the MCH population groups the following:

Population and Demography: Projected Population By Age (2000-2004)

Age Group	**2000**	**2001**	**2002**	**2003**	**2004**
0-4	8,319	9,016	9,745	10,507	11,315
5-9	6,590	6,653	6,868	7,207	7,619
10-14	7,464	7,272	7,009	6,768	6,633
15-19	6673	6998	7276	7454	7501
20-24	4847	5190	5564	5939	6293
25-29	3872	3982	4109	4282	4516
30-34	3113	3407	3508	3615	3723
35-39	2932	2996	3057	3122	3195
40-44	2472	2558	2650	2740	2819
45-49	2111	2174	2224	2277	2344
50-54	1490	1618	1745	1861	1960
55-59	865	957	1064	1180	1299
60-64	610	623	642	677	731
65-69	455	478	498	513	527
70-74	290	289	301	324	355
75+	368	373	379	383	388
TOTAL	**52,671**	**54,584**	**56,639**	**58,849**	**61,218**

Source: Economic Policy, Planning and Statistics Office (EPPSO)

Women of Child-bearing Age: 2000-2004

Age Groups	2000	2001	2002	2003	2004
15-19	3283	3422	3538	3609	3626
20-24	2428	2596	2776	2954	3116
25-29	1930	1991	2060	2150	2269

30-34	1618	1671	1728	1788	1849
35-39	1430	1458	1487	1521	1560
40-44	1243	1282	1318	1352	1383
45-49	962	1019	1074	1127	1176
Total	12,894	13,439	12,676	14,501	14,979

Source: EPPSO

Life Expectancy:

The number of years expected in a population's lifetime often reflects the population's environment and is frequently used with other indicators to measure the population's health status.

Life Expectancy by Sex – RMI: 2000-2004

Year	2000	2001	2002	2003	2004
Male	66.0	66.2	66.5	66.8	67.0
Female	69.7	69.9	70.2	70.4	70.6

Source: EPPSO

Pregnant women, mothers and infants

- The number of teenagers who come in for prenatal care remains very high. During the past five years the rate of teen pregnancy average 18%. The percent of registered births in the country shows Majuro at 71%, Ebeye at 19% and outer islands at 10%.

- In FY 2004 alone the distribution of registered birth by mother's age shows the following:
  - 15-19 age group was 17%
  - 20-24 age group was 35%
  - 25-29 age group was 24%
  - 30-34 age group was 15%
  - 35-39 age group was 7%

Age18 and 19 are included in the teenage age group since the Marshallese culture considers this age group as teenagers who continue to live with the parents even after reaching this age. The culture does not recognize 18 years old as an independent adult.

- There was no maternal mortality during the past five years

During the last five years, there was no maternal death. Early identification of risk pregnancies and referral to the high risk clinics have been improving during these the last five years.

Major cause of Morbidity and Mortality

Data presented here has been covered the whole Marshall Islands (Majuro, Ebeye, and the Outer Islands). The leading causes for morbidity were respiratory, gastrointestinal problems, skin disease, eye problems, fish poison, chicken pox, and pos. RPR.

Major Diseases and Morbidity 2000-2004

Name of Disease	2000	2001	2002	2003	2004
Influenza	1792	2537	3703	4016	5170
Gastroenteritis	1526	2219	1029	1854	2041
Scabies	548	1374	534	772	778
Diarrhea, Adult	69	3294	1954	69	0
Diarrhea, Infantile	49	0	0	1986	1640
Chicken Pox	98	446	313	313	426
Fish posioning	156	311	481	185	251
Conjunctivitis	611	1672	1450	1596	2632
Syphilis	12	74	77	273	172
Amoebias	80	58	213	401	312

Source: Health Planning and Statistics, MOH

Immunization Coverage

Immunization coverage as show here that the percentage of coverage (BCG) which is given at birth is the highest among other vaccines. The percentage drops during the subsequent visits (return visits). Efforts have been taken to improve the coverage. Part of the attempt to improve the level of immunization in the country, were undergoing several meetings with the community leaders, parents, etc to strengthen the outreach activities, including public education on issues on the importance of immunization on schedule for completion.

Immunization Coverage 19-35 month olds, 2000-2004

	2000=3631	2001=3694	2002=3742	2003=3480	2004=2894
Vaccines	**No. %**	**No. %**	**No. %**	**No. %**	**No. %**
BCG	2494=69%	2611=71%	2677=72%	2627=75%	2512=87%
OPV3	2128=59%	2184=59%	2160=58%	1855=53%	1316=45%
DPT3	2081=57%	2071=56%	1840=48%	1526=44%	1186=41%
MMR	2828=78%	2889=78%	2910=78%	2347=67%	1001=35%
HBV3	2041=56%	2191=59%	2233=60%	1984=57%	1435=50%
% of 19-35 month olds with complete immunization series					

according to WHO guideline.					

Source: Health Planning and Statistic, MOH

* Infant mortality rates fluctuate over the past five years as shown below:

In the past five years, the RMI has been trying the reduce its IMR by reducing the rate of teenage pregnancy. Premature babies remains on of the ten top concerns resulting from teenage pregnancy. More effort is put into strengthen our outreach health education activities focusing on teen pregnancy issues.

Infant Mortality Rate: 1999 - 2004

Year	Rate
1999	13 per 1,000 live births
2000	33 per 1,000 live births
2001	26 per 1,000 live births
2002	29 per 1,000 live births
2003	30 per 1,000 live births
2004	23 per 1,000 live births

Source: Health Planning and Statistic: Ministry of Health (MOH)

Infant Deaths

The infants death has not been steady over the last five years. Although, it declined during 2001, more effort has put into strengthening the zone nurse outreach activities.

Top Main Causes of Infants Deaths: 2000 –2004

Year	2000	2001	2002	2003	2004
Premature	15	6	11	16	0
Sepsis	9	11	8	8	6
Pneumonia/Birth Complication	7	5	9	0	3
Congenital Abnormality	4	4	0	7	2
Congenital Health Disease	0	3	0	0	0
Malnutrition	0	0	3	0	0
Severe birth Asphyxia	0	0	0	6	0
Bronchopneumonia	0	0	0	2	0
Aspiration	0	0	0	0	2

Source: Health Planning and Statistic: MOH

Child Death:

The causes of death are severe malnutrition, drowning, and vehicle accident. Effort has been taken to strengthen our outreach activities on nutrition education, including breast

feeding, weaning foods, strengthen our collaboration with parents and the community on child safety.

Registered Child Death: 2004

Year	No. Of Child
2000	12
2001	8
2002	11
2003	14
2004	11

Source: Health Planning and Statistic: MOH
Note: Death from 1-4 years of age

It is indicated that a total of 4,805 visits occurred during FY 2004, including first and the return visits. It further claims that there were six mothers whose ages were below 14. The table also showed that there was a total of 1,015 first visits during the FY 2004, and 3,790 return visits. Action has been taken to strengthen our public awareness on issues concerning the importance of early prenatal care (during the first three months of pregnancy) through the zoning activities. The zone nurses visits the community on a regular basis (Monday thru Friday). Data here indicated that the percentage of pregnant women have been seen during the first trimester (1st three months of pregnancy) is higher than those seen for the first time during the third trimester. With the return visits, data have shown that these pregnant women have come back to the clinics for subsequence visits during pregnancy.

Prenatal Care (All Visits By Trimesters and Age): 2004

	First Trimester			**Second Trimester**			**Third Trimester**		
Age	1st	Return	Total	1st	Return	Total	1st	Return	Total
10-14	2	0	2	1	0	1	0	6	6
15-19	71	70	141	85	196	281	48	388	436
20-24	139	139	278	158	443	601	109	834	943
25-29	57	87	144	89	271	360	52	532	584
30-34	38	50	88	54	155	209	45	338	383
35-39	15	19	34	21	62	83	23	163	186
40-44	3	3	6	2	7	9	3	27	30
Total	325	368	693	410	1,134	1,544	280	2,288	2,568
% of visits by trimester	32%			40%			28%		

Source: Health Planning and Statistic: MOH

Family Planning:

More efforts have to put on education the public, especially to the youth groups, schools health programs, by better coordination with the youth groups, women's organizations, churches, and the community. Expand our outreach health education focusing on family

planning, and other issues concerning family planning. Hiring of three more family planning staff is in process so that the more outreach activities would be provided and better reaching out into the community (reach out for schools drops out/out of schools, etc.).

Family Planning Users

2000-2004

	2000		2001		2002		2003		2004	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<15	18	2	15	7	3	13	0	7	4	3
15-19	452	429	298	844	59	132	39	240	380	179
Total	470	431	313	851	62	145	39	247	384	182

Source: Health Planning and Statistic: MOH

Pregnancy rates among adolescents have been a source of concerned. Many of the pregnancies are a result of inadequate contraceptive practices.

There is increasing recognition of the value of male involvement in pregnancy prevention and family planning. Males represent a small share of clients who receive family planning services.

Sexually active teens are a high risk for sexually transmitted diseases (STDs). The highest rate for STDs are found in sexually active 15 to 19 years with second highest rate found in 20 to 24 years and third highest among 25 to 29 years. Public health outreach teams have expanded to reach the youth in the community, out of schools/school drops out/and those without jobs. Health education on STDs issues were also provided during a weekly radio announcements, news paper, and health fairs.

Sexually Transmitted Diseases: 2004

Gender	Syphilis	Gonorrhea	Chlamydia	HIV/AIDS
Male	182	19	97	0
Female	183	12	157	0
Total	365	31	254	0

Source: Health Planning and Statistic: MOH

Children With Special Health Care Needs (CSHCN)

2004

Children With Special Health Care Needs (CSHCN)

2004

Diagnosis/Management	Number
Joint/bone deformity	41
Ear problem	15
Burns	13
Cleft Lip/palate	15

Other (specific) Arthritis/Spinal cong.	3
Other (specific) Eye problem	9
Total	96

Source: Health Planning and Statistic: MOH

It is shows here that during the year, there were 96 cases who have been identified and confirmed with different types of disabilities that affect their normal daily life. There were also CSHCN/Educational Needs who are in the Special Education Program at the Ministry of Education. With those children with Educational Needs, the number of CSHCN would be 316. These are new cases. Due to island distances with shortage of trained staff to provide the screening needed for identifying children with health care needs, needs for improving the CSHCN service delivery remains a problem. Better coordination between service providers, including the community leaders and health assistant in the outer islands must be improved.

Children with special health care needs (CSHCN) are screened after delivery. The MCH program conducts outreach on a regular basis to identify those who must be seen by physician. Those children who live in the outer islands are brought in to the urban center for annual follow-up and return home. Those CSHCN that need further treatment and follow-up will be referred to Honolulu Shriner's Hospital. From time to time specialists from Honolulu will visit the islands to follow-up with all the cases registered in the CSHCN program, and at the same time, provide screening opportunities. Children who live in the outer islands are then called in on the national radio program to travel to Majuro to see these specialists. The MCHBG pays for travel of these children and their families.

One barrier that is obvious is the lack of specialists in this capacity. Children who live in the outer islands do not have access to the necessary health care services in the health centers. However, the program has established a system to monitor all the registered cases to ensure health services is provided to them on a regular basis.

Another major concern in the MCH populations is age of the pregnant mothers. The teenage pregnancy rates is very high and the age. The program estimates that more than 70% of the teenagers who are pregnant are not married. The educational level of these mothers is not adequate. Most teens that are pregnant either dropped out of school or just graduated from high school. Limited educational background of these young mothers is a contributing factor to the high rates of low birth weights, neonatal mortality rate, postneontal mortality rates.

During the past two years, the Ministry has started an initiative to collaborate with the national women's group called Women United Together in the Marshall Islands (WUTMI) to address the issue on teenage pregnancy. Various teams have started visiting schools in the urban centers, conduct community outreach programs and conduct meetings of women's groups to discuss these issues and how best to address them.

The contraceptive prevalence rate is around 35% which supports the high rates of pregnancy. In this context the RH program has started networking with schools, business community and women's groups to promote the use of condoms. Staff in the RH program have distributed thousands of condoms during outreach activities to the schools and during big events such as the New Year's block party, national celebration events.

There remain a lot of challenges in the years to come. With the changes in lifestyles, there is increase in auto accidents due to alcohol consumption, high rates of suicides, teen pregnancy, malnutrition and non-communicable diseases such as diabetes has now reach the younger age groups. Needless to say, the Ministry of Health continues to see the need to strengthen preventive services. In 2006, the Ministry will change its focus from curative services capacity building to boost the preventive services as the ultimate goal for the years to come.

IV. Assessment of MCH Program Capacity

1. Direct Health Care Services – The health care system in the Marshall Islands is provided through two hospitals in the urban centers of Majuro and Ebeye and 52 health centers that are scattered in each of the communities in 29 inhabited islands and atolls throughout the Marshall Islands. The Majuro Hospital is a 90-bed capacity hospital and Ebeye Hospital has 40 beds.

URBAN CENTERS: Direct health care services are pretty accessible in the two hospitals. Although the prenatal clinics are held in a public health setting, the obstetrics-gyn medical staff works together in providing health services during prenatal clinics and during delivery in the hospital.

Prenatal care is provided in the Division of Public Health under the RH clinics. Services provided to pregnant mothers include support services from the laboratory, dental services, family planning, nutrition counseling and support services from the pharmaceuticals. The pregnant mothers are referred to the two hospitals for delivery. Direct health care services are easily accessible in the two urban centers of Majuro and Ebeye. Community outreach is conducted daily by the public health zone nurses who would refer any pregnant mothers to the prenatal clinics during outreach and home visits The maternity ward is fosters babies to room in with their mothers so the mothers care for the baby immediately after delivery. Having the baby room in with mothers also provide the opportunity for the mother to breast feed the baby. The MOH Breast Feeding Policy was approved in 1994 to have all babies born in the hospital to be breastfed while in the hospital until discharge. The Breast Feeding Policy does not allow mothers to bring formulas into the hospital maternity ward. Upon discharged from the hospital, the nurses in maternity ward will provide the mother and the baby appointments to visit the RH clinics for postpartum and well-baby clinics in Public Health.

It must be noted that every mother who comes to the hospital for delivery will bring along a traditional birth attendant who will stay with the mother to monitor her condition with the nurses in the maternity ward. Training of traditional birth attendants is conducted

by the MOH to ensure they understand the procedures for sterilizations and other needs for the mother during delivery. Once the baby is born, the pediatricians will examine or screen the baby for abnormalities. Due to limited number of medical staff in the Marshall Islands, there are no audiologists who can provide the screening services for CSHCN. However, continued monitoring of children is conducted during well-baby clinics for special needs by the medical staff. Once a child is identified for special needs, a physician will do the medical evaluation for further medical services overseas.

Screening for STDs and other infectious diseases is provided during prenatal clinics in the two urban centers. Treatment for STDs is provided throughout the clinical visits after pre- and post-test counseling is completed. Pap smear is provided during prenatal clinics and to all women who visit the public health clinics for physical examinations for school entrance and food handling. Because of the age of pregnant mothers, a high-risk clinic was established for all high risk pregnant mothers. These mothers are closely monitored during their visits to the prenatal clinics. Family planning services counseling is provided during prenatal clinics. After delivery, the nursing staff from the RH will visit the mothers to make appointments for family planning services and well-baby clinics.

OUTER ISLANDS: Delivery of health care services in the outer islands is provided through the 58 health centers. Except for three communities, most the communities in the outer islands do not have any electricity. The health centers were built with three rooms for in-patient, out-patient clinics and a treatment room equipped with proper medical supplies. The population of each community in the outer islands range from 80 to 500. The distance from outer islands to urban center of Majuro is 80 miles up to 800 miles.

Each health center is managed by only one health assistant. Fourteen (14) of these health centers are managed by female health assistant, and the remaining 44 health centers are managed by male health assistants. Although direct health care is provided in these health centers, not all pregnant women can access prenatal care because of the cultural barriers. On each community or atoll, most people would refer pregnant mothers to prenatal clinics. For the outer islands, dental teams would visit communities on a regular basis to provide dental services to the populations residing in these communities and conduct screening and check-ups to students in the elementary schools. The outer islands health centers have only one health assistant as the primary care staff assigned for each health centers. Because of lack of electricity, dental services is not provided for preventive services. There are not dentists assigned to each health centers. So the staff from the Division of Dental Services in the urban centers travel to communities in outer islands to provide dental services.

Each health center is equipped with a radio communication system whereby a health assistant call in to the hospital emergency room for medical consultation anytime. When medical referred cases are sent in from outer islands, the MOH will arrange for the small airplanes to pick-up the patients and transported to the two hospitals in Majuro and Ebeye as well. The Director of Outer Islands Health Centers is on standby 24-hours in case

there are high risk cases that need to be medically evacuated from the outer islands. Every medical evacuation from outer islands must be done during daytime only since the airstrips do not have any landing lights.

2. Enabling Services

The health care system allows for any individuals in the Republic to have access to direct health care services. Even in the remote islands, basic health care services is provided in the health center. Zone nurses who conduct outreach in the urban centers refer pregnant women to the prenatal clinics to access health services.

There are no pediatric centers in the RMI. There are three private clinics in Majuro: one is a family practice, one for dental services and the third one is for optical services for obtaining eye glasses. People in the RMI have the choice either to visit these clinics or visit the hospital for the same health services.

The Marshall Islands have an universal insurance where every individuals in the country is eligible for off-island medical referral under the Basic Health Care Plan. Every government employees in the country contribute about 4% of their salaries to the Basic Health Care Plan. The people who do not have jobs, including those who live in the outer islands, however, are included and eligible for health care under the Basic Health Plan.

Additionally, the Ministry as the only state agency to provide health care services to the population of the Marshall Islands, does not turn away any patient that cannot pay for their medical bills. Arrangements can be made to pay for medical bills. The deposit fee for one outpatient visit is $5 only. This fee covers the costs of pharmaceuticals and visit. There are no charges for prenatal care, immunization, postpartum and family planning services.

Costs for delivery in the hospital for pregnant mothers is $5 for those mothers who attend prenatal clinics during the first trimester and $20 for those who attend prenatal clinics for the first time during second and third trimester. Charge for hospital admission is $5 per night. For the outer islands, there is no charge for home delivery. The mothers have the choice to deliver their babies in the health center or their homes with the health assistant in attendance and supported by the traditional birth attendants. Delivery in the health center costs also $5 or less.

Basic health care services is provided for the outer islands populations. Population in each community in the outer islands ranges from 90 up to 500, and the distance from outer islands to the urban center range from 80 miles up to 800 miles. Transportation to outer islands is through the regular government and private field trips ships and the Airline of the Marshall Islands (AMI).

Medical referral from outer islands to the hospitals in the urban centers are carried out on a regular basis if necessary. The health provider in each community would radio in for

medical consultation regarding critical patients. Patients can be monitored through the radio system throughout the night until the following day when arrangement would then be made for the airline for medical evacuations form outer islands.

Each health center is managed by only one health assistant who is the sole health care providers for each community. There are no pediatricians, obstetrics-gynecologists, ENT and other specialists in these health centers. However, health teams from Public Health travel to the outer islands, the members of the teams consists of a physician, nurses from RH/MCH, Immunization program, TB/Leprosy, staff from Health Education Office, Mental Health Program and dental nurses. The comprehensive teams spend at least one week in each atoll. The larger atolls require the teams to stay for two weeks in order to travel within the atoll to provide health care services to all people living in these communities.

Traveling within an atoll requires use of a motor boat which takes up to at least one hour traveling from one community to another depending on the distances. Because of the lack of electricity in the outer islands, it is necessary to communicate in advance to outer islands health centers to ensure fuel is available for transportation and refrigerator is available to store vaccines for the duration of the trip.

There are barriers that can inhibit communities in the outer islands not to access services in dental care, family planning, immunization, STD screening and other services. These barriers include bad weather, mechanical problems of the airline and lack of fuel in the outer islands for transportation. Funding for travel from the urban centers to outer island can be a barrier as well. Traveling on motor boats are costly, particular the fuel. Transporting a mother who needs to be medically evacuated from a community where there is no airstrip to another community with an airstrip for the air plane for pick-up is not reliable. All depends on the barriers listed above.

3. Population-Based Services

The Ministry of Health's capacity to provide population-based services is through the two hospitals and 58 health centers. The two hospitals can only provide primary and secondary health care services and very limited tertiary care. It is clear in the previous discussions that outer islands health care system has very, very limited health care services for the MCH population groups. There are unmet needs of the MCH populations in the outer islands as listed:

- Prenatal care – not all pregnant women can have access to prenatal care due to cultural barriers where pregnant mother cannot visit prenatal clinics if she is a 'family' of the male health assistant.
- Family planning services – same reason as listed above.
- Immunization programs – pregnant mothers, other adults and children can access immunization services when health teams visit these islands/communities due to the fact that not all communities have electricity, including the health centers. If there is no electricity, the health centers cannot store vaccines in the refrigerators.

Few of the health assistants have been trained in immunizations so the public health nurses do send out the vaccines only in the cold boxes.

- Screening for CSHCN is done only when health teams visit.
- Diarrheal diseases is common in most communities in the RMI.
- The need for community awareness is very much needed. Due to the distance from one community to another and from the urban centers to the outer islands, there is inconsistency of visits from staff in Health Education & Human Services for educational awareness programs and activities. Additionally, transportation to and from outer islands may not be reliable all the time.

The unmet needs of the MCH populations in the urban centers include but not limited to:

- Lack of aggressive outreach to refer young pregnant mothers for early prenatal care.
- Those who do not have the means to access transportation consider distance between communities and the hospitals to access health care as a barrier.
- Limited health educational materials that can be disseminated for access health services
- Although the national radio system can be used to disseminate information, most people do not listen to the radio all the time.
- Costs of healthy foods is very expensive so the cheaper and not-healthy foods are often bought.

Outreach efforts by staff in the PHC Bureau is the aim of the Ministry. The Ministry is currently doing preparations work aiming to strengthen preventive services in the urban center of Majuro as a start. Majuro is the capital and where more than half of the population in the RMI reside. Mobilizing the community leaders in each zone to work with the MOH staff will be the first step to identify the needs of the community. Before the end of the year, a position paper on strengthen local capacity in preventive services will be finalized for endorsement by the Government before any steps will be initiated. The senior staff of the Ministry will be working closely and collaboratively to develop an action plan to implement this initiative.

4. Infrastructure-Building Services

Before the end of 2005, a new facility that will house both curative services and preventive services will be opened for service as part of the Ministry of Health's expansion of health care. This facility which is located in Majuro has been designed to have outpatient and public health in the same section of the building. Having both programs of services right next to each other will allow for integration of health care services where all the medical staff in the Ministry will work along side. Additionally, the RH clinic area has been designed to have both prenatal and male clinics at the same time. However, male clients will have a separate door to access male clinics and not to interfere with the prenatal clinics which is acceptable to the Marshallese culture.

Medicaid and Supplement Security Income (SSI) are not part of the MOH health care system since the Marshall Islands is not eligible for these programs. However, funding

under the MCHBG, Immunization and SSDI are provided to conduct school outreach and school health programs. The staff in Public Health just completed the Immunization Plan to implement Immunization Act in the schools to have all students complete their immunization requirements before entering schools, have sealant fissures provided to students in grades 1, 2, 6 & &. A School Health Program Coordinator has been recruited to ensure schools in are in compliance with the legislations. The staff in the Immunization Program have already met with school principals and staff from the Ministry of Education to discuss the school health programs.

In collaboration with other agencies, a Memorandum of Understanding has been signed between the following agencies: Ministry of Education, Ministry of Health, College of the Marshall Islands, Head Start Program and the Majuro Atoll Local Government. This MOU serves as a basis of understanding that services for children with special health care needs will be coordinated between these agencies to ensure CSHCN are not neglected. The Inter-Agency Committee charged the Ministry of Health to provide direct health care services for CSHCN which include physical examination, dental services, ENT services and immunization; Ministry of Education to provide necessary education to these children enrolled in the school system; and for other agencies to support and implement outreach and educational activities and programs for CSHCN and their families.

Members of the National Inter-Agency Committee meet on a regular basis to review and evaluate services provided to the CSHCN and their families. The family members of the CSHCN are very supportive of the activities planned for their children enrolled in the program.

V. Selection of State Priority Needs

A. Background and Overview

The results of the two separate seminars with MOH key staff and community partners clearly show the need for the MOH to strengthen its local capacity to improve preventive services at all levels. The following are the recommendations regarding the 10 Essential Public Health Functions (ERHF) to the Ministry of Health:

1. EPHF #1: Monitor health status to identify community health problems.

1) It is recommended for the MOH to have a reliable and maintainable Health Information System (HIS) to strengthen and improve the data collection for both rural and urban centers.

2. EPHF #2: Diagnose and investigate health problems and health hazards in the community.

2) It is recommended the MOH should immediately recruit an Epidemiologist or bio-statistician to support and monitor the present surveillance system.
3) It is recommended that the MOH establish protocol for disclosing relevant information in time of epidemic and/or outbreak of diseases.

4) It is recommended that MOH must collaborate with Environmental Protection Authority (EPA) to investigate health hazards in the community.
5) It is recommended that MOH initiate an emergency response plan in close partnership with the Office of the Chief Secretary.

3. EPHF #3: Inform, educate and empower people about health issues.

6) It is recommended that MOH develop a comprehensive capacity building initiative for its staff to certain extend, to other interested groups in the community.
7) It is recommended that the Health Promotions and Human Services staff create a strong health education outreach activities programs addressing the needs of the community with respect to health issues.

4. EPHF #4: Mobilize community partnerships to identify and solve health problems.

8) It is recommended that the MOH develop a well-define partnership with non-government organizations, and the community at large through public health zoning activities, symposiums and workshops.

5. EPHF#5: Develop policies and plans that support individual and community health efforts.

9) It is recommended that MOH evaluate the health services delivered by outer islands health care centers, its cost effectiveness and cost efficiency.
10) It is recommended that record management in the outer islands be upgraded and well monitored.
11) It is recommended that staff development and capacity building should be a high priority of the MOH.
12) It is recommended that MOH reassess to upgrade the salary of its staff all across the board.
13) It is recommended that MOH strengthen programs for individuals and members of the community to participate in initiating any health programs to be implemented in the community.

6. EPHF #6: Enforce laws and regulations that protect health and ensure safety.

14) It is further recommended that MOH revitalize the MOH Legislation Committee to actively study and establish pertinent rules and regulation that will address both public health and social issues related to health and lifestyles.

7. EPHF #7: Link people to needed personal health services and assures the provision of health care when otherwise unavailable.

15) It is recommended that the zone nursing must be strengthen for a strong community outreach program.

16) It is recommended that referral clients from the community should be more defined and well coordinated for continuous health care.
17) It is recommended that significant public health services should be provided as part of the zone nursing services to ensure children receive immunization requirement during home visits and distribution of vitamins to children who are not in school.

8. EPHF#8: Assure a competent public health and personal health care workforce.

18) It is recommended to continue retraining program for public health nurses to upgrade their skills.
19) It is recommended that MOH provide opportunities for staff to attend frequent local seminars.

9. EPHF #9: Evaluate effectiveness, accessibility and quality of personal and population-based health services.

20) It is recommended to have MOH conduct a six-month evaluation and monitoring program.
21) It is recommended to have each program have a quarterly evaluation programs to determine whether services provided are intact and satisfactory to the needs of the population.
22) It is recommended for the MOH to extend needed health care services to outer islands population.

8. EPHF #10: Research for new insight and innovative solutions to health problems.

23) There is no research institution in the RMI. However, the Ministry of Health to continue providing information to the public regarding health issues.

Reviewing these recommendations shows that lack of information about the intentions and goals of the MOH is limited. Furthermore, community participation and preventive services are recommended in order to reach the all population groups including those of the MCH. Based on these recommendations and the reviewing of data from previous years, the MOH has selected the listed State Priorities.

B. State Priorities

1. To continue to reduce the Infant Mortality Rate
2. To reduce the rates of teenage pregnancy
3. To increase rates of prenatal visits during the first half of pregnancy
4. To reduce neonatal mortality and morbidity
5. To increase access to preventive services for women who are at risk for cancer.
6. To reduce the rates of sexually transmitted diseases among women of child-bearing age.

7. To strengthen the Health Information System to provide essential data to strengthen health care services focusing on preventive services.
8. To improve accessibility to the MCH/CSHCN services for children 0-21 years and their families.
9. To improve preventive services for school children in dental services, immunization and nutrition education.
10. To strengthen screening programs on hearing to infants and young children.

For the next five years, the MOH will focus on ways to improve the services and programs for the MCH population groups and also to focus on the recommendations provided for the essential public health functions listed. The MOH data and statistics show the need to strengthen local capacity to provide curative services in order to reduce the number of medical referral for off-island medical care. However, in the long run, the aim is to strengthen preventive services at all levels of health care to enhance the curative services provide. The concept of primary health care and preventive services calls for integration of services and self-reliance which will ultimately improve health status of any country in the world. This is the goal of the Ministry of Health in the years to come.